MRI Centers Of Texas

MRI • X-Ray • CT

Central Scheduling: Phone: (844) MRI-OF-TX • Fax: (210) 569-7799
or email your referral to referral@mrioftx.com

Date _____ **Transportation** □**Yes** □**No** □**Male** □**Female** **Pregnant** □**Yes** □**No**

Patient Name _____ D.O.I. D.O.B. _____

Address _____ City, State & Zip _____

Patient Phone # _____ Email _____

Referring Physician _____ Diagnosis Code(s) _____

Physician's Signature _____ Contact Name _____

In making this referral, the referring physician certifies that it is medically necessary.

Office Phone # _____ Fax # _____ Email _____

Insurance Provider _____ Phone # _____

Legal Representative _____ Phone # _____

PLEASE ARRIVE 15 MIN PRIOR TO YOUR SCHEDULED APPOINTMENT TIME AND PLEASE BRING YOUR VALID IDENTIFICATION.

Weight:_____IMPORTANT: Please let us know if you weight over 300 lbs. or have any metal objects in your body

MAGNETIC RESONANCE IMAGING (MRI)

Select Body Part Below:

	□With Contrast	□Without Contrast	□With & Without Contrast
□Cervical Spine			
□Thoracic Spine			
□Lumbar Spine			
□Head / Brain			
□Knee		□RT	□LT
□Hip		□RT	□LT
□Shoulder		□RT	□LT
□ Hand		□RT	□LT
□Wrist		□RT	□LT
□ Elbow		□RT	□LT
□Abdomen			
□Pelvis			
□Other			

X-RAY

□Cervical Spine		
□Thoracic Spine		
□Lumbar Spine		
□Chest		
□Ribs		
□Ankle	□RT	□LT
□Foot	□RT	□LT
□ Knee	□RT	□LT
□Wrist	□RT	□LT
□Hip	□RT	□LT
□Hand	□RT	□LT
□Shoulder	□RT	□LT
□ Elbow	□RT	□LT
□Pelvis		
□ABD/KUB		
□Other		

CT SCAN

	□With Contrast	□Without Contrast	□With & Without Contrast
□ Cervical Spine			
□ Thoracic Spine			
□ Lumbar Spine			
□ Chest			
□ Head/Brain			
□ Pelvis		□ ABD	
□ Knee			
□ Ankle			
□ Hip		□RT	□LT
□ Shoulder		□RT	□LT
□ Hand		□RT	□LT
□ Wrist		□RT	□LT
□ Elbow		□RT	□LT
□ Other			

Special Instructions:

Maps & Locations on Reverse Side

www.MRICentersofTexas.com